

HFS Prior Approval Form for  
Synagis (pavilizumab)  
2006-2007 Season

SYNAGIS PRIOR APPROVAL REQUEST FORM

- ☐ Baby Weight Change Only  
☐ Baby Turns Two Years Old During Season

A. PHYSICIAN INFORMATION			ALL Information Requested On This Form Must Be Complete				
Physician Name: _____		DEA #: _____	License #: _____				
Prescriber is a Pediatrician? <table border="1"><tr><td>YES</td><td>NO</td></tr></table>		YES	NO	(If NO, list specialty) _____	Office phone #: _____		
YES	NO						
B. PHARMACY INFORMATION							
Pharmacy Name: _____		Pharmacy I.D. #: _____	Pharmacy Phone #: _____				
C. PATIENT INFORMATION							
Patient Name: _____		DOB ____/____/____	Patient 9 digit IDPA Recipient Number: _____				
Gestational Age at Birth: _____		Diagnosis: _____	<input type="checkbox"/> first season	<input type="checkbox"/> second season	<input type="checkbox"/> other _____		
Birth Weight: _____		Current Unclothed Weight (and date)*: _____	Dose: 15mg/kg = _____ Nearest vial size: 50mg / 100mg				
D. PATIENT INFORMATION							
<input type="checkbox"/> Infant born at 28 weeks gestation or earlier with birth date after October 1, 2005							
<input type="checkbox"/> Infant born at 29 - 32 weeks gestation or earlier with birth date after April 1, 2006							
<input type="checkbox"/> Child born after October 1, 2004 with hemodynamically significant congenital heart disease							
<input type="checkbox"/> Child born after October 1, 2004 with chronic lung disease requiring treatment within the last 6 months (define treatment in section E)							
<input type="checkbox"/> Child born after October 1, 2002 requiring mechanical ventilation for lung disease							
<input type="checkbox"/> Child born between 32 and 35 weeks gestation and is currently under 6 months of age with the following risk factors: (list below)							
E. NOTES:							
Important: To prevent delay, fax relevant patient information along with this form or provide such information below. If weight changes during the season, please indicate new weight and date below.							
F. PHYSICIAN or DESIGNEE'S SIGNATURE: _____			Date: _____				

COMPLETE ALL INFORMATION TO INSURE PROMPT PROCESSING

CREATED 7/28/2005

FAX TO : 217-524-7264  
ATTN: MEDICAL COMMITTEE

**ILLINOIS HEALTHCARE AND FAMILY SERVICES  
SYNAGIS PRIOR APPROVAL ROUNDING CRITERIA**

<b>WEIGHT RANGE - KG</b>	<b>DOSE</b>	<b>50mg Vial</b>	<b>100 mg Vial</b>
0 - 3.6 kg	0 - 54mg	1	
3.7 – 7.3 kg	55 - 109mg		1
7.4 - 10.6 kg	110mg – 159mg	1	1
10.7 – 14.0 kg	160 mg – 210 mg		2

The above reflects the most commonly dosed amounts. Doses above 210 mg. can be approved based upon child's weight.